AISMA Doctor Newsline
A helpful resource for the practice business

aisma
association of independent specialist medical accountants

follow @AISMANewsline

Issue 23 Autumnn 2013

Know the financial value of all your ENHANCED services

Smart GPs and managers are looking to enrich the value of their enhanced services. **Kathie Applebee** – whose practice now offers 35 of them – lays out some vital ground rules and tips for the future

Enhanced services were introduced in 2004, alongside the QOF (Quality and Outcomes Framework). Both sets of directives have evolved but it seems that enhanced services may continue to grow while QOF potentially shrinks.

The advantage of enhanced services in England, if not yet in the other three nations, is that they can be offered to other providers in a way that QOF services cannot. If practices do not want to offer NHS Health Checks, for example, the local pharmacy, supermarket or out-of-hours provider can step in.

In the short-term, hard-pressed practices may breathe a sigh of relief at this state of affairs. Workload and recruitment problems are taking their toll, and sharing the work seems like an obvious solution, not least to the politicians.

However, services once lost may not be regained, and your patients may become used to going elsewhere for their healthcare, turning a trickle into a flood.

My own practice currently offers 35 enhanced services. Like the QOF, these services require targeted

data entry, a clear understanding of the claiming requirements, a claiming process - although CQRS (the Calculating Quality Reporting Service) in England is due to take much of this on in due course - and working to defined standards.

Faced with this workload, practices may miss out some required steps, and either fail to do essential work or lose out at the claiming stage.

Understanding the requirements

Each service needs a champion who will read and disseminate the clinical requirements, keep up to date with changes and direct data entry requirements. It is often not enough for someone simply to ensure that the correct codes are available.

There also needs to be an understanding of how the clinicians will be presented with either the need or the opportunity to offer these services and then record them. For example, for minor surgery and minor injuries, we start with a prompt to obtain informed consent.

Data entry

Data entry is the obvious key to successful claiming. Providing easy access to the required codes depends on your GP IT systems but may also require individuals to be mindful of claiming opportunities.

Dealing with a childhood immunisation in a clinic provides a structure to the encounter, whereas opportunistic dementia queries may be overlooked in routine consultations.

The latter services can benefit from rotating poster reminders in key places such as the staff toilet door or the kitchen. The 'tip of the week' can advise of changes and remind of easily-overlooked services.

Claiming

Claiming may become easier in time but it is a problem at present for English practices, with contracts held with NHS England, via the Area Team (AT), the CCG, and Public Health - via the local area or county council.

I have found it helpful to list all the services under their contractual areas, with key contacts listed against individual services. You may also wish to keep a central spreadsheet of the areas and their claims so that you can monitor trends and check payments.

Value for money

The key with enhanced services in the delicate balancing act between keeping out external providers (where this risk exists or may arise) and offering a service for patients at their own practice, and ensuring that the service is cost effective. This requires at least annual reviews of each service, with realistic costings.

In this context, realistic does not necessarily mean accurate. Accurate would include an element for rent, lighting, heating, refreshments and other expenses.

In the interests of political expediency, you may choose to accept these standing costs and simply calculate the costs that would not be incurred should the service end: for example, nurse salaries (including pension and national insurance contributions), consumables and admin staff support.

Where services do not generate a profit or, worse, are a cost to the practice, consider the wider implications as well as exploring potential efficiencies in the way in which the service is offered.

If you do a special clinic which suffers from DNAs, could you use routine scattered appointments so that the DNAs have less impact?

Where prevalence is low, could this be improved by better training, or by admin staff checking for missing or miscoded entries? The latter is an additional cost but, depending on the service, could help generate a profit.

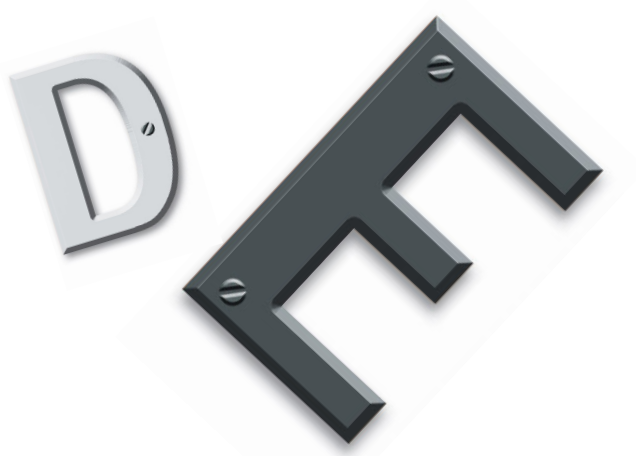
Finally, look ahead to a more competitive arena and consider the implications of either expanding each service to include patients from further afield or having to bid for (and possibly losing) it.

You need to know the financial value of each service to prepare for either eventuality and, as always, forewarned is forearmed.

BMA advice for 2013/14:

http://tinyurl.com/na23yop

© Kathie Applebee 2013, organisation psychologist for primary care, and strategic management partner at Tamar Valley Health Group Practice



OPINION

Now is the time to review your practice income

Seamus Dawson, Committee member, AISMA

We are now nearly six months into the 2013-14 financial year and with autumn here it is now a good time to critically review your practice performance and set your targets for the rest of the financial year.

One area to pay particular attention to is your practice income because an unexpected drop could result in a surprise fall in profits.

A good place to start is with your prior year practice accounts.

These should provide a breakdown of your income sources and from there you can start to identify trends and fluctuations. Your AISMA accountant can assist you in providing an analysis of your income streams and may also be able to advise you on additional sources which may be available.

After identifying the sources of income the next step is to assess the impact on your practice if a particular source was to reduce or cease.

For example, most GP practices obtain close to maximum QOF points which can count for approximately 20% of the total GMS/PMS income. If your practice is not embracing the QOF changes introduced for the 2013-14 financial year in full then there could be a drop in overall practice income.

Being aware of potential reductions in income is important as it gives you time to review your options:

- identify new sources to replace the lost income
- reduce expenditure accordingly, or
- accept a drop in your overall practice profits.

Identifying new sources of income is not always straightforward these days, especially with the reduction in overall primary care funding.

Reducing your practice expenditure again may not be possible unless there are specific costs attached to the lost income stream. Therefore, a drop in overall practice profits may be inevitable and if this is the case then partners' drawings will probably need to be adjusted accordingly.

Of course some GPs may choose to accept, and indeed plan for, the drop in profits to give them a better work life balance and/or cut their marginal rate of tax and superannuation.

But by not planning ahead and anticipating drops in income, and budgeting accordingly, you could be opening up problems that may be more difficult to resolve later on.

Assessing your current income streams and your overall practice performance - and planning for the future - should be on the agenda for your next partners' meeting.

Remember, a drop in profits should never come as a surprise. If need be, call on your AISMA accountant who is in a good position to provide you with a synopsis of your practice performance and help you plan for fluctuations in the future.

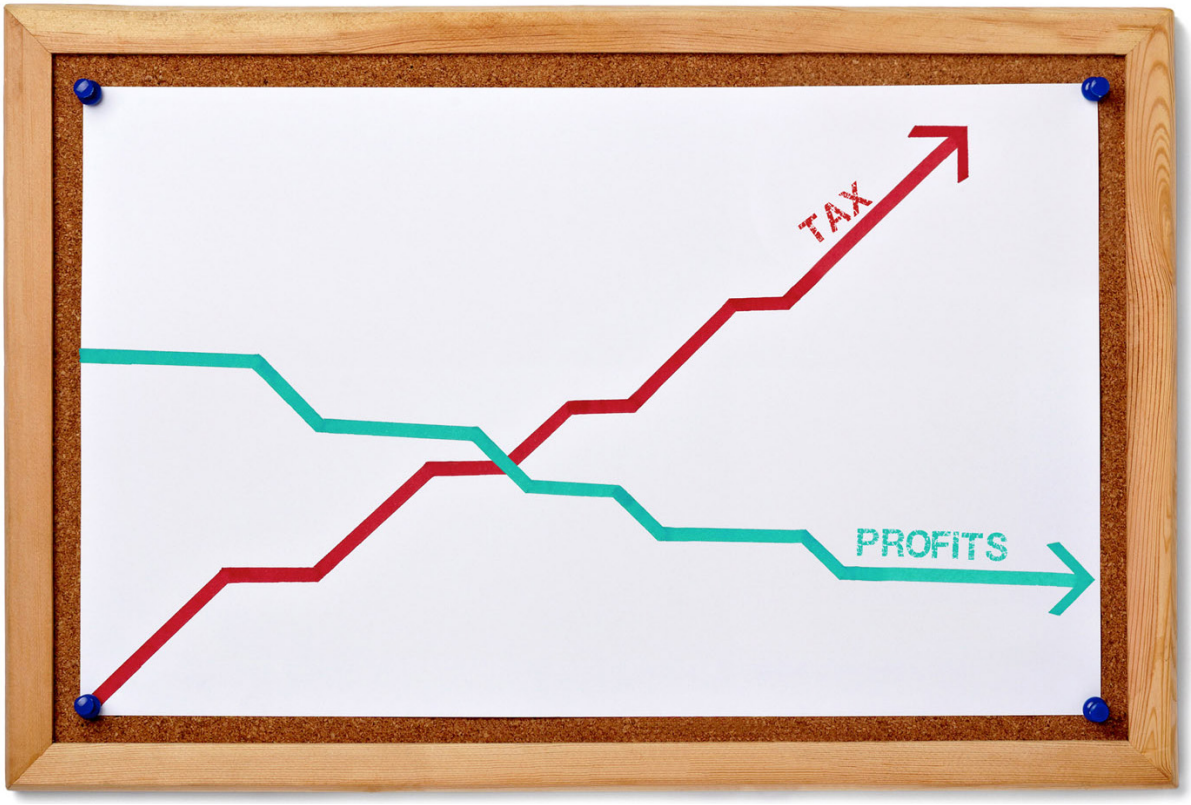
Hit back against your tax attack

There is a recurring big question on a lot of GPs' lips. **Francis Whitbread*** answers it - and shows what you can do to ease the tax pain

'So why am I paying more tax when my profits are going down?' Many GPs across the four nations have been quizzing their accountants about what seems such an unfair financial hit.

While practice profits have often at best stagnated, and in many cases fallen, there has not been a corresponding reduction in the amount of income tax GPs are paying on their partnership profit shares.

Unfortunately the fall in practice profits coincided with the introduction of the 50% tax rate for income in excess of £150,000 (now 45% from 6 April 2013)



and the gradual loss of the personal allowance for income over £100,000.

There was also a 1% increase in the rate of Class 4 National Insurance contributions.

A constantly recurring theme when I meet the GPs I act for is ideas from me on ways they can cut their tax bill.

My list below covers some of my more common suggestions but they always come with a caveat: namely that there must be commercial justification and a long term benefit from the action taken.

For example, expenditure through the partnership on new plant and machinery - or personally into a tax efficient investment - must bring with it a long-term benefit.

With that thought kept firmly in mind, consider the following areas:

Plant and machinery

For the two years commencing 1 January 2013 the annual investment allowance for expenditure on plant and machinery has been increased to £250,000.

This means, for example, that a practice with a 31 March year-end will be entitled to an annual investment allowance of £250,000 for the year ended 31 March 2014. If it wished it could spend that amount on plant and machinery - and write the entire amount off for income tax purposes.

Clearly that scenario is unlikely. But if the practice does need to update its equipment there may be merit in doing so while the annual investment allowance remains at the £250,000 a year level to ensure the maximum tax deductions are obtained.

Remember, plant and machinery for tax purposes comprises not only items of equipment such as computers and furniture but also any apparatus used in carrying on the business.

This includes items which are fixtures in buildings such as the electrical and heating systems. And if the practice owns its own surgery it may be worth investigating whether there are any claims available for this type of expenditure which had not been made previously.

Alternative investments

Given the restrictions imposed by the annual and lifetime allowances there is little scope for making further pension contributions to obtain the tax relief that is available for these.

However, alternative investments could be considered if they are appropriate as part of the overall retirement planning strategy.

For example, 30% of the amount invested into a qualifying Enterprise Investment Scheme (EIS) is currently available as a deduction from one's income tax liability.

A similar relief is available for investment into a venture capital trust (VCT). A qualifying EIS investment would be into an unquoted stand alone trading company (some trades which are land backed such as farming, are excluded).

Another attraction of qualifying EIS investments is that if the shares are held for a requisite period, normally three years, any capital gain on a subsequent sale of the shares is tax free.

Finally, the capital gains tax liability on a disposal can be deferred if the gain is reinvested into qualifying EIS shares.

I have even seen some GPs use investment products which give a 100% tax deduction under the rules relating to the business premises renovation allowance (BPRA).

Clearly the risk associated with the investment has to be balanced against the tax deduction that is available and needs to be considered as part of the overall investment strategy.

But it should be noted that EIS investments also carry inheritance tax advantages because they will normally qualify for 100% business property relief after they have been held for two years.

Make a company

If the practice has substantial non-NHS income then consideration can be given to setting up a separate limited company to receive this income.

If a substantial part of the income can then be extracted in the form of dividends there will be a saving of National Insurance and the net of tax income will be higher.

However, these tax savings need to be balanced against the extra compliance costs in operating through a company and the fact that a company is a more cumbersome structure when it comes to partnership changes.

ISAs

Make sure you are using your annual ISA allowance as this does allow some income to be received tax free albeit that the ISA allowance is not particularly attractive at £11,520 for the year ended 5 April 2014.

Beware the band

Try to ensure that your level of taxable income falls outside the band at which the personal allowance is lost as the marginal tax rate there is 60%.

For the year ended 5 April 2014 the personal allowance will be lost on the basis of £1 for every £2 of income for income between £100,000 and £118,880.

Records records records..

Make sure you keep records of all expenses paid personally that you think may be tax deductible against your practice earnings and send details of these to your accountant so he or she can advise on the position.

Keep AISMA accountant updated

Finally, and most importantly, keep your accountant up to date with proposed investments and other tax planning ideas you have so he or she can advise on the most tax efficient approach.

Like GPs, we cannot diagnose properly if we do not know all the facts; neither can we advise effectively after the transaction has already taken place.

'If only you had told me what you were doing first' is something I dislike saying to any client.

Of course, none of the above points are anything new or radical but for many I hope they are a useful reminder of ways of reducing the annual tax bill.

The above comments are intended to give general guidance only and for advice on your specific position you should refer to your taxation adviser.

They are also intended to deal purely with the taxation implications of the proposed transactions and should not be taken in any way as giving advice from an investment or any other point of view.

AISMA Doctor Newsline is published by the Association of Independent Specialist Medical Accountants, a national network of specialist accountancy firms providing expert advice to medical practices throughout the UK.
www.aisma.org.uk
AISMA Doctor Newsline is edited by Robin Stride, a medical journalist and former finance editor of Doctor magazine.
robin@robinstride.co.uk

* Francis Whitbread is an accountant with Edmund Carr LLP, Chelmsford.
** David Walker is senior tax manager with Moore and Smalley, Blackpool.

follow @AISMANewsline

Dr Simon Bradley gives seven areas to consider to maximise Any Qualified Provider contracts for your practice

A GP's 7 tips to be an AQP contract winner

The opportunities for drawing new resources into general practice are few and far between right now and practices are increasingly looking to see whether Any Qualified Provider (AQP) contracts can help them.

2012-13 was a preparation year with a relatively restricted menu of services in the transition from PCT to CCG.

But now, as CCGs start to grow in confidence, they are widening this contracting mechanism to a broader range of services - ones that may be increasingly attractive to general practice.

GPs and their practice managers are right to be interested but AQP is not a pot of gold and there are a number of key areas that practices must be aware of if they are to get the best out of them.

1 Establish a provenance for your service

Having a realistic prospect of getting approved for an AQP contract means being able to demonstrate you are a competent provider of the service being tendered.

So if you have aspirations to be a community provider of vasectomy then it would help if one of your team had current experience of providing vasectomies and better still if your practice had experience of being the provider.

Consider offering a service to your NHS patients now even if it is outside of core contract. Or provide it privately to non-registered patients if you have an eye to providing this service in the future.

Then when the opportunity comes you will be off to a flying start.

2 Know the numbers

There may be a number of drivers when considering whether to bid for an AQP tender.

It may be to improve a care pathway and offer a better experience for patients or to provide a more cost effective service for your health community or to generate extra income for your practice.

Often it will be a combination of these factors. But even then the practice needs to have an accurate understanding of the cost to provide a service.

Few practices will wish to make a loss, something which could impact on their capacity to fulfill their core GMS or PMS contracts. On the positive side there are opportunities to provide services at marginal cost but AQP contracts give no guarantee of volume or value. Costs in bidding and working up a service may be considerable and margins tight in an increasingly competitive market.

3 Geographical coverage

AQP contracts usually cover at least one CCG area and it is frequently a mandatory contractual requirement that the service shall be delivered within a defined travel time on public transport.

This may bring a requirement that the practice delivers the service from locations that are some distance from their surgery/ies.

Working with other practices can help overcome this but bidding jointly adds layers of complexity such as defining legal relationships between lead and subordinate practices, service consistency and governance.

It is vital to have identified how you will address this issue and all mandatory requirements right from the start so as not to waste resources on a fruitless submission.

4 Monitor Supply2Health

All AQP contracts have to be advertised on the NHS Supply2Health website www.supply-2health.nhs.uk

Forthcoming contracts and bidder events are published here and it is a rich source of information on AQP generally. So there is a benefit in familiarising yourself with it early on.

The bidder events are information sharing events hosted by the commissioner and give the prospective bidding practice the opportunity to clarify issues about the tender.

They also allow you to check out any opposition and more usefully they allow for dialogue between potential providers, which can become an early step in collaborative working that can culminate in the submission of a joint bid.

5 Cost kit and caboodle

All practices now should be CQC compliant and registered but every non-core service must also meet CQC requirements and be properly equipped.

Business cases may be difficult to achieve in the context of no guaranteed revenue where expensive specialist equipment is required and not fully utilised.

CCGs often require extensive reporting and that can demand sophisticated patient management systems.

This is usually fine if you are using a single practice system but it may be complex and costly when working across multiple sites.

Getting clinical information back to referring practices in a timely and appropriate format is essential and may require additional investment by the practice provider.

These fixed costs give a competitive advantage to larger providers where their investment in equipment, communication platforms and software may be spread across multiple AQP service lines.

6 Achieving volume

As I have mentioned, AQP contracts give no guarantee of volume so it would be entirely possible to be approved as an AQP provider by a CCG and then have no referrals and generate no revenue.

Every AQP service will have cost the provider a significant amount of time and therefore money before it even treats its first patient and this cost has to be recouped before any surplus can be counted.

As margins are slim, £20 surplus per patient might be considered reasonable but it takes a throughput of 500 patients to break even if costs of setting up the service are a relatively conservative £10,000.

Even where practices might expect their own patients to choose in-house services, all but the largest practices are likely to rely on external referrals to become profitable.

So this means you should look to have a unique selling point as a provider, a budget for marketing your service, and slick communications systems to make life easy for referring practices.

7 Collaborate, federate or franchise

Getting a solid business case is key to being able to provide an effective sustainable service and working together allows increasing economies of scale, better margins and a reduction in individual risk.

Loose local collaborations are really only a stepping-stone because committing to a contract is legally binding and so local arrangements end up needing the security of a legal agreement.

Federations can work well where practices share a vision and commitment. They can bring high patient volumes where conflict of interest issues have been addressed and underpinned by legal agreements to create a new legal entity - be it social enterprise or a for profit company.

That legal entity can then carry the risk and limit the liability of individual practices. Franchise-like arrangements can help put a conflict of interest airlock between practice commissioners and practice, offer much greater economies of scale and reduce risk while preserving individual practice autonomy and individuality.

Whichever you choose by working together there is much to gain and little to lose.

Dr Simon Bradley MRCGP is founder and medical director of Quality Practice Ltd
www.qualitypractice.co.uk

PAYRALYSED!

Crazy pension and tax rules mean brave new world GPs are paying four figure sums to work for CCGs.
David Walker** explains why

Albert Einstein once said: 'If you can't explain it simply you don't understand it well enough.'

The great inventor, however, only had the theory of relativity to communicate and not GP pensions in the NHS scheme.

In previous AISMA Doctor Newsline articles I have touched on whether to opt out of the scheme or defer, cease added years, and increase contribution levels. I have also looked at pension tax charges and the sustainability of the scheme.

Since then, of course, we have seen a number of developments that are confusing on their own and when viewed together can be mind-blowing. But they must be viewed together.

Action taken based solely upon one particular factor may end up costing you heavily. No action should be taken without seeking advice from a suitably qualified and experienced specialist independent financial adviser.

Briefly, the more recent developments are:

- From April 2013 – The introduction of CCGs and some rather well paid posts for GPs.
- From April 2014 – Reduced levels of Annual Allowances and Lifetime Allowances (AA and LTA) and the introduction of Fixed Protection (2014) and Individual Protection.
- From April 2015 – The introduction of a new NHS Pension Scheme, with protection for some members of the existing schemes and the possibility of a further 'Choice' exercise to transfer benefits to the new scheme.
- From April 2016 – The end of contracting-out from the earnings-related part of the State Pension.

For now I would like to consider the first of these changes and how it links in with the second.

CCG positions

There is presently much confusion regarding these positions. Some of this revolves around employment status issues.

It is proving difficult for some accountants and many CCGs to reconcile that an 'office' holder may suffer deductions of tax and national insurance (NIC) under Pay As You Earn, but be classed as self-employed for tax purposes and have the income pensioned as practitioner income on a GP Solo form, and therefore eligible for seniority, for NHS pension purposes.

But, there you have it. Some might call it a learning curve. Sometimes it feels like Snakes and Ladders.

Anyway, ignoring the odd foible as above, what are the implications of taking on a CCG chair or other Board post?

Let us assume you are a 1995 scheme member and that the post you take on at 1 April 2013 is for two days a week, with a salary of £64,000 based upon a whole time equivalent (WTE) of £160,000. This is a properly employed position with tax, NIC and superannuation contributions all deducted at source.

Many of you will be aware of the GP pension flexibilities I have mentioned before. Consider the position:

31 March 2013

Dynamised career practitioner earnings £2,500,000 over 25 years GP service. 8 years were spent in training/hospital posts before the practitioner service.

Most beneficial pension at 31 March 2013 is gained by uplifting the GP pension proportionately for the pre-practitioner service as follows:

Practitioner: 2,500,000 x 1.4% x 33/25 = pension of £46,200

31 March 2014

Dynamised career practitioner earnings now £2,700,000 and you have served one part-time year in your CCG post (WTE 365 x 2/5 = 146 days).

Option 1 is to treat the CCG pay as practitioner pay. The dynamised pot would therefore be £2,764,000 and the pension would be as follows:

Practitioner: 2,764,000 x 1.4% x 34/26 = pension of £50,602

Option 2 is to receive a separate officer pension in respect of the CCG post. The benefits would then be as follows:

Practitioner: 2,700,000 x 1.4% x 34/26 = pension of £49,431

Officer: 160,000 x 146 (365 x 2/5 for WTE) / 29,200 (80 years) = £800

Total pension = £50,231

This is not quite as beneficial as treating the CCG pay as practitioner pay.

Option 3 is the further option of not uplifting the practitioner pension for pre-practitioner service. The pre-practitioner service was officer service too, so that can be lumped in with the CCG post as follows:

Practitioner: 2,700,000 x 1.4% x 26/26 = pension of £37,800

Officer: 160,000 x 3,066 (8 year+365 x 2/5 for WTE)/29,200 (80 years) = £16,800

Total pension = £54,600

Lucky you – your pension has increased from £46,200 at the end of one year to £54,600 at the end of the next. That is an increase of £8,400.

Reducing AA and LTA levels

From April 2014 the level of the AA is falling from £50,000 to £40,000 and the LTA from £1.5m to £1.25m.

What does the above pension increase arising mainly from the CCG post mean in this context?

AA

Allowing for a 2.2% cost of living increase of the starting year figure of £46,200, the rise in the capital value for AA purposes is £140,288.

If you have no unused allowances brought forward, that is £90,288 above the current limit and £100,288 over the limit from next year. Assuming the top tax rate of 45% applies, that is either £40,630 in 2013-14 or £45,130 in 2014-15.

How much would you take home from the CCG job? Assuming all your allowances and lower rate tax bands are applied to your remaining practice income, and ignoring NIC, you will receive £38,400 (£64,000 less 40% tax).

So, there is the deal. And it is something even Einstein would struggle with. You take on a responsible position with your CCG in the brave new world of commissioning and not only do you not get to keep any of the money they are paying you, it will cost you £2,230 on top of that, or possibly £6,730 if it were 2014-15. Ouch!

There is, of course, a facility for the scheme to pay the charges on your behalf, but benefits would be reduced at retirement to recover this.

LTA

The capital value of £54,600 for Lifetime Allowance purposes is £1,255,800. In 2013-14 that is below the £1.5m limit. In 2014-15, assuming you have no form of protection in place, you would be liable to a charge if you retired on that level of pension (i.e. no actuarial reduction).

It is perhaps as well that the scheme pays this for you and reduces your pension benefit, because there is none of the CCG money left to pay it.

Advice should again be taken in any attempt to mitigate such charges.

Lack of space in this issue prevents me touching on any of the other topics yet, but hopefully the above has given you some idea of what the repercussions of a relatively simple decision (do I take the CCG post?) may be.

This is without considering what the effect on potentially valuable Enhanced Protection may be, whether any of the new 2014 protections would be available/relevant and how all that might be influenced by a new scheme in 2015.

Oh, and the end of contracting out is going to cost you a fair amount too.

The above views reflect only those of the author. The scenarios shown are entirely fictitious, but represent realistic figures based upon many cases seen through experience. Tax rules and pension regulations used in the above calculation are correct at the time of going to print, but are subject to change in the future.